

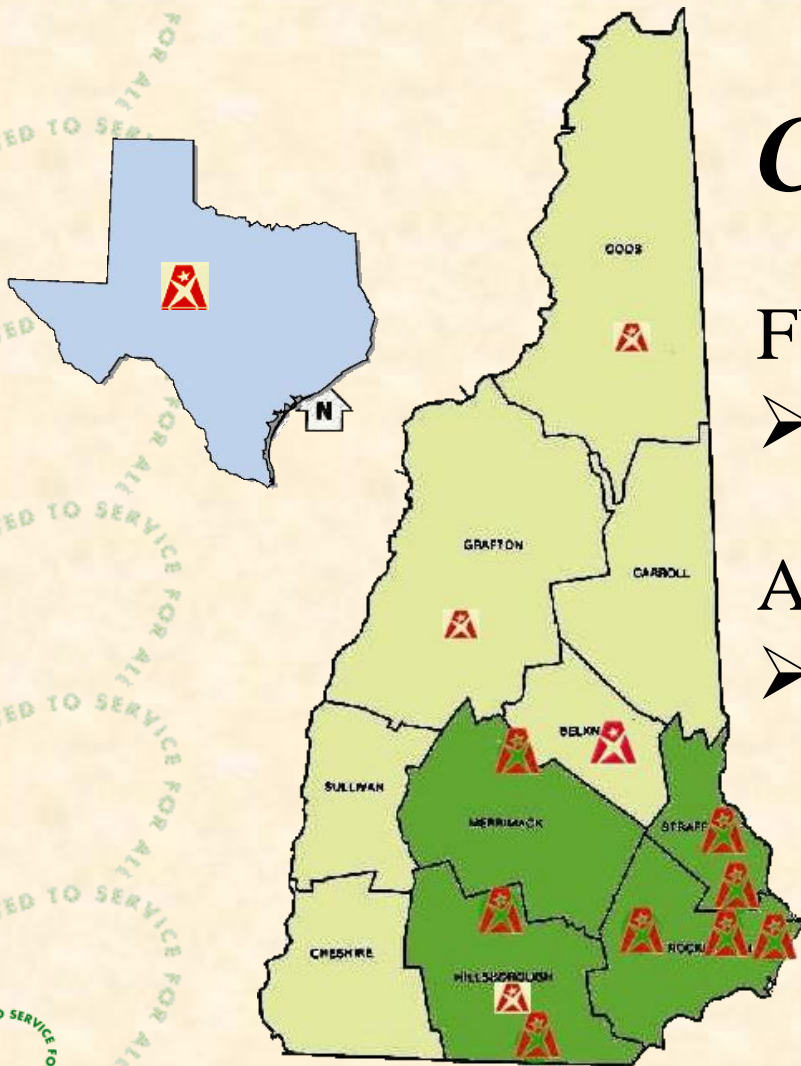
Community Health Access Network (CHAN)

**a Health Center Controlled Network
(HCCN)**

501(c)(3) Founded 1995

**2008 HIMSS Davies Award Winner
Community Health Organization (CHO) Category**

CHAN's HCCN Members



Current Membership:

24 sites (19 in NH and 5 in TX)

FULL Members

- 15 sites + 2 Healthcare for the Homeless vans

AFFILIATE Members

- 9 sites

Ingredients for realizing Quality Improvement:

Agency Leadership

Make QI a Priority, identify QI team

Tools/Infrastructure

Data collection

Data reporting

Data distribution

QI Leadership

Implement strategies/model (ie PDSA, clinical micro-systems)

Leadership: “Big vision” helps drive QI Priorities

- QI priorities are determined both by agency AND the healthcare environment, to include
 - Funders
 - Federal and State reporting requirements/initiatives (i.e. MU, PCMH)
 - Insurers
 - Network wide QI initiatives

Tools/infrastructure: Data Collection

- Fully implemented and integrated Meaningful Use Certified Electronic Health Record/Practice Management infrastructure (over **70,000** active patient records)
 - Central server architecture; **37 virtual** servers supported on site
 - Secure Patient Portal (email, appts, prescription refills, lab results, pt “view only” access to their records)
 - Robust **Security** Infrastructure (BotNet Filter, Intrusion Protection Software)
- Electronic Forms
 - Internal decision making body; to include clinical staff familiar w/existing workflows
 - Vendor or internal expertise in e-form authoring
- Staff Training, to include manuals/documents
 - where document w/in the EHR tool

Data Collection (often includes decision support)

PHQ-9 Screening done and patient's score is identified as a new or follow-up episode of care:

Mental Health Screen: Donald Test

PHQ-9 Questionnaire | Suicide Risk Assessment | Additional Screening Tools

Patient Questionnaire - PHQ-9 **PHQ2** **?**

1. Over the last 2 weeks how often have you been bothered by any of the following problems?

Not at All (0) - Some Days (1) - Most Days (2) - Nearly Every Day (3)

a. Little interest or pleasure in doing things..... 1

b. Feeling down, depressed, or hopeless..... 2

c. Trouble falling/staying asleep, sleeping too much..... 1

d. Feeling tired or having little energy..... 0

e. Poor appetite or overeating..... 0

f. Feeling bad about yourself - or that you are a failure or have let yourself or your family down..... 1

g. Trouble concentrating on things (i.e. reading paper/watching TV)..... 1

h. Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual..... 1

i. Thoughts of hurting yourself or that you would be better off dead..... 1

[Click here to go to Suicide Risk Assessment](#)

Total Score: 8

2. If you checked off any problem on this questionnaire, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

3. Have the above symptoms been present most of the time for 2 yrs or more with no symptom free periods for greater than 2 months?

☒ Yes ☐ No

Active Depression Diagnoses: [Update Problem List](#)

Is this a new episode of depression care? **(Yes)** **No**

Initial PHQ-9 Score: 8 **No previous score**

Follow-Up PHQ-9 Score:

Previous Follow-Up PHQ-9 Scores: No previous scores

Consider alternative diagnosis

Add one of the following diagnoses to the Problem List

Depressive Disorder, Major-Managed at HC

Depressive Disorder, Minor-Managed at HC

Depressive disorder, Dysthymia-Managed at HC

Alternative Diagnosis

Re-evaluate within 4-8 weeks

Patient Self Care Plan

Last Reviewed/Updated: **Due** **P** **C**

Patient Handouts

Depression Care

Counseling Services

FAQ About Antidepressants

View Other Available Handouts

Suicide Risk Assessment - Tab **Additional Screening Tools - Tab**

Provider determines new or updated diagnosis/problem

Depression diagnosis is added to the problem list with onset date:

Update Problems

Potential problem list for: **Donald Test** ⚠ Drug interactions ☒ Active ☐ Inactive

Description	Code	Onset Date	End Date	Entered By	Responsible	Assessment
AXIS I: DEPRESSIVE DISORDER, MAJOR-MANAGED AT HC	ICD-296.20	02/19/2013	<No End Date>	Rebecca Roos		
HEALTH MAINTENANCE, ROUTINE	ICD-V70.0	07/31/2002	<No End Date>	Barry Giglio MD	Barry Giglio MD	
ANTICOAGULATION THERAPY	ICD-V58.61	10/20/2010	<No End Date>	Rebecca Roos	Rebecca Roose	

☐ This patient has no known problems (NKPROB)
☐ Problems list reviewed during this update
Problems have not been reviewed

Assessment / Comment: ☐ New ☐ Improved ☐ Unchanged ☐ Deteriorated ☐ Comment Only

Effects of this update:
Added new problem of AXIS I: DEPRESSIVE DISORDER, MAJOR-MANAGED AT HC (ICD-296.20)

Click OK to save all changes. Click Cancel to discard all changes.

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Tools/infrastructure: Data Reporting

- Staff or vendor expertise in report development
- Query capabilities included in EHR system
- Robust Data Warehouse with drilldown reporting to support Clinical and Operational Report Development (i.e. network dashboard reports, clinical quality indicators for individual sites)
- Members have capability to develop their own reports to meet their individual needs
 - Chronic disease management
 - QI Programs
- Determine how to present the data
 - Total agency results?
 - By provider?
 - Provider compared to total agency?

Quality Data IN = Quality Data OUT

Report is run to identify newly diagnosed depression based on ICD-9 code(s) and onset date along with initial PHQ-9 score and date of last PHQ-9 screening.



Patients w/Newly Diagnosed Depression & PHQ-9 Date Community Health Center

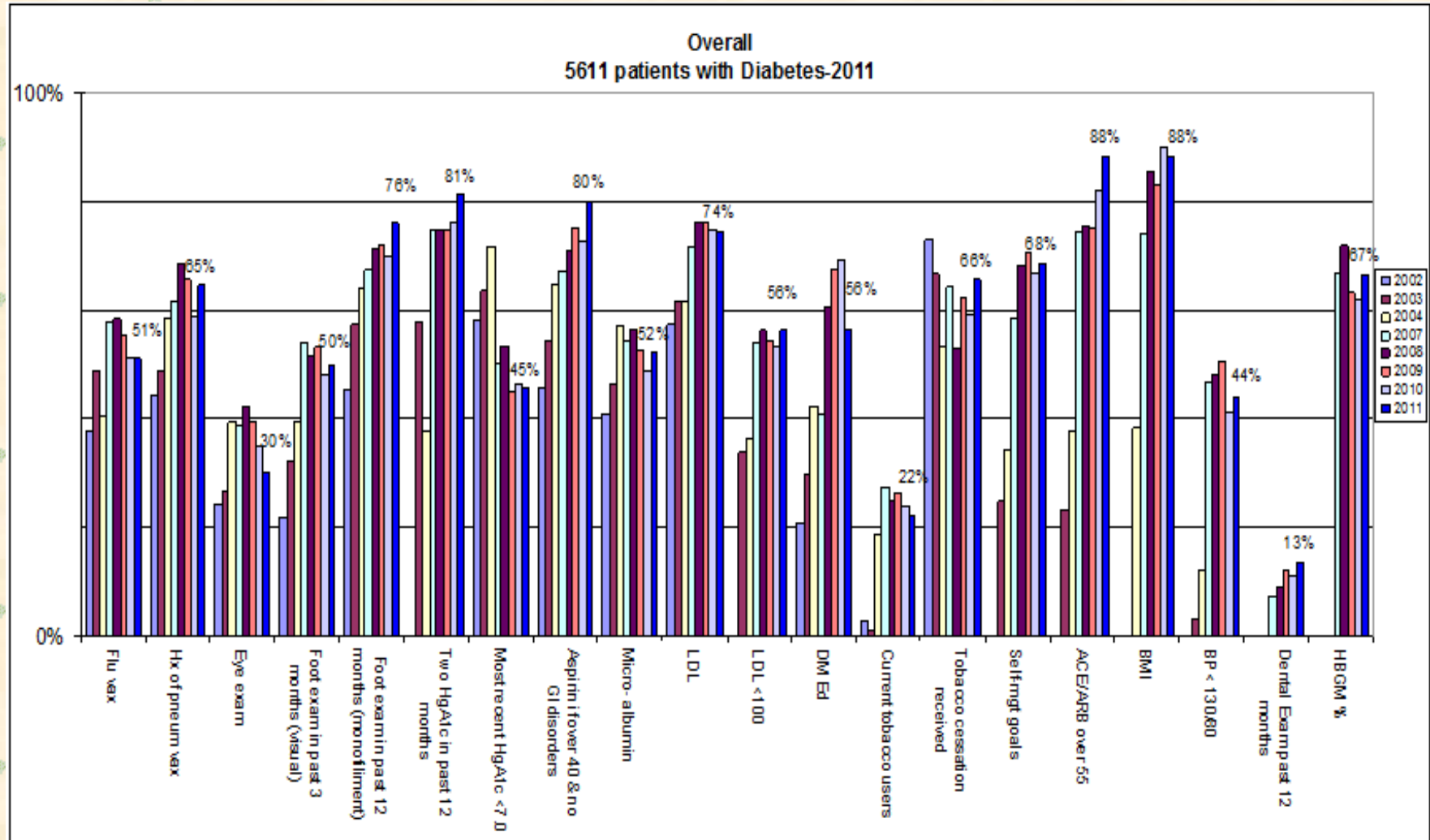
Provider Name <input type="text"/>				
<u>Patient Name</u>	<u>Depression Diagnosis</u>	<u>Depression Onset Date</u>	<u>1st PHQ9 Score</u>	<u>Date Last PHQ9</u>
██████████	Depression	12/18/2012	8	1/24/13
██████████	Depression	1/31/2013		1/31/13
██████████	Depression, Major, Mild	12/12/2012		
██████████	Depression	12/26/2012	21	2/6/13
██████████	Depression	1/23/2013	21	12/20/12

Provider Totals:

# Distinct Patients w/ Newly Diagnosed Depression:	10
# Distinct Patients w/ Newly Diagnosed Depression & PHQ-9 last 90 days	8
% Patients w/ Newly Diagnosed Depression & PHQ-9 last 90 days:	80.00 %

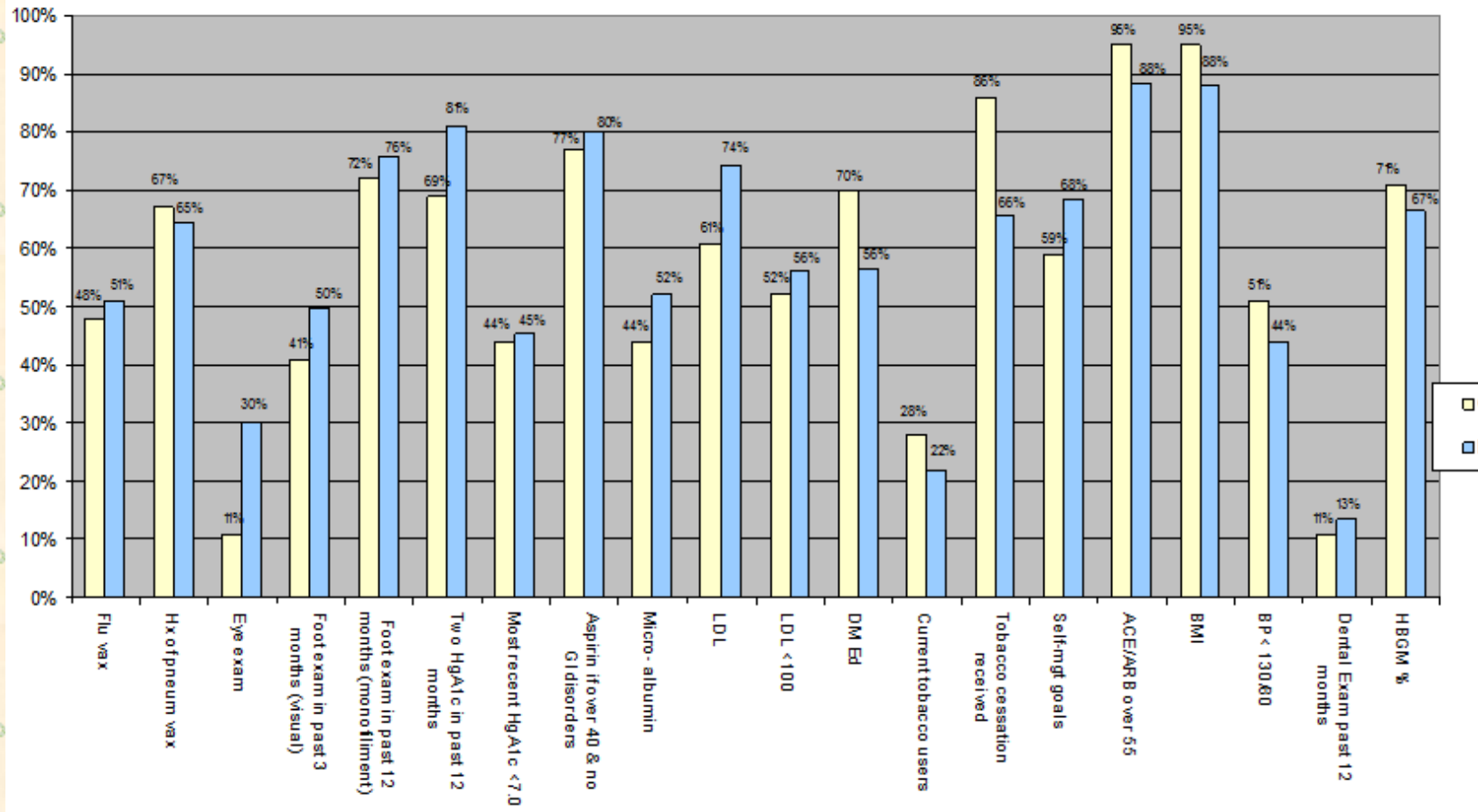
Trended DM data: 2002-2011

20 CQMs, all 8 HC participants



Trended DM data: 2011

1 HC vs. all 8 HC participants



Trended MU results, by Provider

HC#7 EP results for Meaningful Use Core Objectives using GE reports embedded in EMR (10/1/12-12/31/12)

	Use CPOE for Medication orders (30% goal)			Enable drug-drug and drug-allergy interaction checks (requires yes/no attestation)	E-Rx (40% goal)			Record Demographics (language, gender, race, ethnicity, DOB) (50% goal)			Maintain Prob List (80% goal)			Maintain active Medication List (80% goal)		
	Num	Den	%		Num	Den	%	Num	Den	%	Num	Den	%	Num	Den	%
Provider #1	262	327	80.1%	yes	232	493	47.1%	367	383	95.8%	383	383	100.0%	383	383	100.0%
Provider #2	224	298	75.2%	yes	301	323	93.2%	322	342	94.2%	342	342	100.0%	342	342	100.0%
Provider #3	159	202	78.7%	yes	241	406	59.4%	100	210	47.6%	210	210	100.0%	210	210	100.0%
Provider #4	399	477	83.6%	yes	722	1026	70.4%	460	497	92.6%	497	497	100.0%	495	497	99.6%
Provider #5	409	505	81.0%	yes	632	843	75.0%	513	563	91.1%	563	563	100.0%	555	563	98.6%
Provider #6	227	289	78.5%	yes	358	481	74.4%	293	309	94.8%	308	309	99.7%	308	309	99.7%

LHC EP results for Meaningful Use Quality Measures (chosen with CHAN members) using GE reports embedded in EMR

	CORE MEASURE: Pts age 18-64 w/BMI outside "normal" w/in past yr and f/u is documented			CORE MEASURE: All active pts 18+ with diagnosis of HTN who have been seen for 2+ visits with blood pressure recorded			CORE MEASURE: Pts age 18+ seen for 2+ med visits queried about tobacco use w/in 24 mos			MENU MEASURE: Pts 18+ identified as tobacco users w/in past 24 mos who have rec'd cessation intervention MENU MEASURE			MENU MEASURE: Female pts 21-64 who rec'd Pap test			MENU M 65+ w pne
	Num	Den	%	Num	Den	%	Num	Den	%	Num	Den	%	Num	Den	%	Num
Provider #1	69	222	31.1%	31	42	73.8%	58	58	100.0%	4	4	100.0%	481	589	81.7%	33
Provider #2	64	234	27.4%	36	39	92.3%	45	45	100.0%	2	2	100.0%	444	573	77.5%	14
Provider #3	32	128	25.0%	81	95	85.3%	29	33	87.9%	****	****	****	186	258	72.1%	51
Provider #4	94	282	33.3%	81	95	85.3%	94	102	92.2%	4	5	80.0%	477	559	85.3%	109
Provider #5	113	375	30.1%	110	118	93.2%	128	128	100.0%	8	8	100.0%	484	675	71.7%	42
Provider #6	41	181	22.7%	45	53	84.9%	32	34	94.1%	2	2	100.0%	221	313	70.6%	73

Tools/infrastructure: Data Distribution

- **Identify need**
 - Who needs this data?
 - WHEN do they need the data (weekly? Monthly? Quarterly?)
- **How do they want to receive this data?**
 - Post reports to a central report server so staff can run when convenient
 - Distribute via email
 - Distribute at meetings

Dashboard Report Schedule

Report	Data from	Source	Frequency
Administrative			
No show rates	CHAN	Centricity PO	Annual/July
Patient Satisfaction	CHAN	Opinionmeter	Annual/May
Consolidated client demographics and Analysis	Site	Centricity PM	Annual/April
Payer Mix	Site	Centricity PM	Annual/April
Top 20 Diagnoses for Office Visits	CHAN	Centricity PM	Annual/July
Operational Reports			
Orders			
% completed orders for Tests and Procedures		Centricity PO	In dev.
Billing			
E&M Coding match rate	Site	Centricity PM	Annual
Risk & Safety monitors			
Allergies recorded/updated (% of visits in 12 mos)	CHAN	Centricity PO	Annual/Oct.
Clinical Reports			
Diabetes Measures Trended			
HgbA1c rate (2/year)	CHAN	Centricity PO	Monthly
Average A1c level	CHAN	Centricity PO	Monthly
% with self-management goals set	CHAN	Centricity PO	Monthly
Asthma Measures Trended			
% with recorded classification level	CHAN	Centricity PO	Monthly
Anti-inflammatory meds rate / persistent disease	CHAN	Centricity PO	Monthly
% with Action Plan	CHAN	Centricity PO	Monthly
Prenatal			
1st Trimester enrollment			Annual
Pediatric			
Lead screening rate for 2 yr olds	CHAN	Centricity PO	Annual/Aug.
Adolescent			
% with risk assessment performed / recorded	CHAN	Centricity PO	Annual/Jan.
Geriatrics			
Flu shot rate	CHAN	Centricity PO	Annual/Oct.
Cancer Prevention			
Colorectal screening rate >50 yrs	CHAN	Centricity PO	Annual/April
Mammography rate	CHAN	Centricity PO	Annual/April
Pap Smear rate	CHAN	Centricity PO	Annual/April
Mental Health			
Prevalence rates of Depression and Anxiety	CHAN	Centricity PO	Annual/July

We have the Data; how do we use it?

- Population Management
- Benchmarking (against national, state, local outcomes)
- Track patient self management
- Risk management (respond to medication recalls, outbreaks)

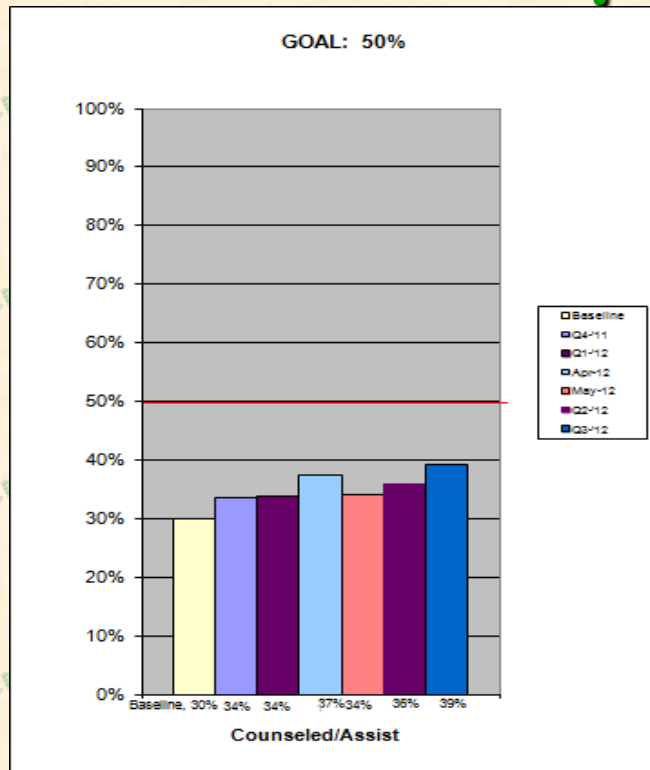
We have the Data; how do we use it (cont) ?

- Identify areas for improvement

Improvement strategies may include

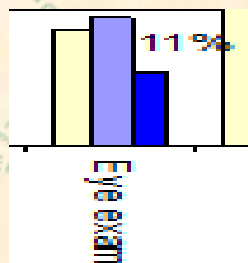
- clinical micro-systems improvement
- additional staff training
- Patient outreach
- Pre-visit planning
- Peer outreach/collaboration

Clinical micro-system improvement (example)



- Assessment (uses 5P's)
- Theme
- Global Aim
- Specific Aim
- Change Ideas
- Measure(s) Phase – EHR data to inform process, PDCA cycle. Use more data to evaluate if a change is working

Patient Outreach (example)



- HC partnered with state to support outreach to DM population who have not had a documented eye exam in past 12 mos (mailing campaign)
- Collaborated with local agencies (ie Lions Club, optometrists) for access and fee support
- Included eye exam in HC “Diabetes Day”

HTN pre-visit summary (pre-visit planning tool, used during morning huddle)

PRE-VISIT SUMMARY - HTN

PATIENT NAME: [REDACTED] PHONE: AGE: 24 Years Old GENDER: Female D.O.B.: 05/14/1988

ADDRESS: [REDACTED]

NEW PT EST PT

SCHEDULED APPT: 02/26/2013, 8:00 AM, Sick Visit, [REDACTED]

REASON FOR TODAY'S VISIT: _____

Date of Last BP: 01/15/2013

Last BP Value: 100/60

Vitals BP: ____/____ Height: ____ Weight: ____ Head: ____ Temp: ____ Pulse: ____ Resp: ____ Pulse Ox: ____

PROTOCOLS DUE: TD BOOSTER or TETANUS IMMU or TDAP, BG FASTING, BG FASTING or BG RANDOM or GLUCOSE SER, CALCIUM, RBC or WBC, CHOLESTEROL, SODIUM or POTASSIUM or CHLORIDE or CO2 or CO2 TOTAL, BUN, CREATININE, EKG or EKG INTERP.

HTN pre-visit summary (cont.)

X-Rays/Referrals Needed:

☐ Eye
☐ Dental
☐ Podiatry
☐ Mammography
☐ Colonoscopy
☐ Referral, Other:

Services Needed:

☐ Review/ set Goals ☐ FOBT
☐ Tdap ☐ Flu ☐ Pneumovax

HTN Recommendations :

Indicate all tests to order at this visit

☐ Baseline BG (age 20 and over)
☐ Baseline Calcium (age 20 and over)
☐ Baseline RBC / WBC (age 20 and over) Baseline
☐ BUN (age 20 and over)
☐ Baseline Creatine (age 20 and over)
☐ Baseline Protein Urine (age 20 and over)
☐ Na (Yearly)
☐ K (Yearly)
☐ EKG (Every 5 years)

Additional Labs Needed:

☐ BMP ☐ CMP ☐ Glucose
☐ HgbA1c ☐ LFTs ☐ Lipid Profile
☐ Urinalysis w/C&S ☐ Urine Microalbumin
☐ CBC w/diff w/platelets

SELF MANAGEMENT GOALS:

I will walk 30 minutes 3 x a week

I will set a date to quit smoking

Barriers to achieving goals: _____

Peer Collaboration

Diabetes Education Program (DEP) 2011

Documented Clinical Measures

Highest documented %'s in 2011

Influenza vaccine in past 12 months

HC#7

HC#1

History of pneumococcal vaccine

HC#7

HC#1

Dilated eye exam in past 12 mths

HC#7

HC#1

Visual Foot exam in past 3 mths

HC#8

HC#7

Monofilament exam in past 12 mths

HC#1

HC#3

Contact Info

HC#1

[email address](#)

HC#2

[email address](#)

HC#3

[email address](#)

HC#4

[email address](#)

HC#5

[email address](#)

HC#6

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HC#7

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